Printed: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E534		B. WING		11/25/2015		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STAT	E, ZIP CODE			
ATTICA L	ONG TERM CARE FAC	CILITY	302 N BO ATTICA,	OTKIN KS 67009				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	INITIAL COMMENTS			F 000				
	The following citations represent the findings of a health resurvey and complaint investigations #84283, #85470, and #93181. An electronic revision of the 2567 was sent to the							
	facility on 11/30/15.	of the 2007 was some						
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO			F 242				
	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.							
	This Requirement is not met as evidenced by: The facility identified a census of 47 residents. The 22 residents sampled included 2 reviewed for choices. Based on observation, interview, and record review the facility failed to provide bathing choices for 1 (#3) of the 2 residents reviewed for choices.							
	Findings included:							
	- Review of resident #3's Admission MDS (minimum data set), dated 2-9-15, revealed the resident had a BIMS (brief interview for mental status) of 9, indicating the resident had moderately impaired cognition. The resident required extensive assistance of 1 for personal hygiene, required physical help for part of the bathing activity with supervision provided by staff. He/she had limitation in ROM (range of motion) in the resident's bilateral lower extremities. Review of preferences revealed it was very important for							
LABORATOR'	Y DIRECTOR'S OR PROVIDER	NSUPPLIER REPRESENTATIV	E'S SIGNATURE		TITLE	(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		17E534		B. WING		11/2	5/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ATTICA LONG TERM CARE FACILITY			302 N B ATTICA	OTKIN ., KS 67009				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 242	Continued From page 1			F 242				
	the resident to choose between a tub bath and shower.							
	The CAA (care area assessment), dated 2-9-15, documented the resident required some assistance with daily personal hygiene, showering and toileting.							
	Review of the resident's, undated, Bathing Preferences and Practices, revealed the resident preferred baths 2 times a week during the evening shift.							
	Review of care tracker documentation (certified nurse aide care of residents documentation), revealed the resident received showers only during the past 3 months.							
	On 11-16-15 at 10:47 a.m., the resident when asked about the facility honoring bathing choices, reported he/she had to take a shower now, but would like to be offered a whirlpool or a tub bath, but it never comes up. He/she had always taken a tub bath at home and enjoyed soaking in the water.							
	On 11-17-15 at 2:53 p.m., direct care staff L, stated the staff have a bathing schedule which lets staff know when each resident wants their bath. This resident is scheduled on Tuesday and Friday evenings for a shower. The option of a tub bath is not offered to the resident with each bathing time. If a resident wanted a tub bath or a whirlpool, the staff would need to take the resident to a different part of the facility, and it could mess up the bathing schedules.							
	stated, a preference s	o.m., social service staf sheet is filled out for eac n. These are filled out b	ch					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			1 ' '	E CONSTRUCTION	(AS) DATE S		
	17E534			B. WING		11	/25/2015
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ATTICA L	ONG TERM CARE F	ACILITY	302 N B ATTICA	OTKIN , KS 67009			
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	Staff admitting the residence of the facility policy, celders, documented choice regarding with and which type prefer. This informatheir individualized The facility failed to and preferences for 483.15(h)(2) HOUS MAINTENANCE Staff years).	resident. 5 p.m., licensed nursing sent usually decides when what type of bath he/sheing staff member will askine of admission. 7 a.m., administrative nurgeference sheet indicates have a tub bath in the evoluted be the expectation that dent's desire to bathe insting. Idated 9/14, for bathing of did the elders will be given hich type of bath they presided what days, time of a for bathing the resident valion will be documented plan of care. In provide the resident's character at tub bath for bathing. SEKEEPING & ERVICES Ovide housekeeping and the snecessary to maintain and comfortable interior.	they these rsing s the ening. at the a efer. the vould on	F 242			
	The facility reported Based on observati failed to provide ma services for the fac	is not met as evidenced I d a census of 47 resident ion and interview, the fac aintenance and housekee ility environment and as in 2 of 3 halls, and in t as.	s. ility eping				

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		17E534		B. WING		11/2	25/2015
	OVIDER OR SUPPLIER ONG TERM CARE FA	CILITY	302 N E	RESS, CITY, STA BOTKIN A, KS 67009	TE, ZIP CODE		
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F 253	Continued From page 3			F 253			
	Findings included:						
	- Observation, on 11-23-15 at 10:00 am, with maintenance staff D, revealed the following resident areas in need of cleaning an/or repair.						
	A) 300 hall						
	 A resident room contained a wall with 7 nails extruding approximately 1/2 inch. Maintenance staff D stated there probably were pictures hanging in this area. A resident room contained 17 small holes where nails had been removed. Maintenance staff D stated the rooms are painted when a resident leaves if there is time before another resident moved in. 						
		contained a sink back sport aminate approximate					
	4.) A resident bathrood brown discoloration a	om contained a toilet wi	ith a				
	5.) A resident room contained discolored areas on the back splash behind the 2 sinks.6.) The west hall common living area contained a bathroom with scrapes in the paint along the lower wall area approximately 2 by 2 inches.		eas				
	7.) A recliner in a resident room contained ripped areas approximately 4 inches in length on both sides of the lower front.		• •				
	·	ent room contained area eximately 24 inches in h					

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, ,		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	17E534			B. WING		11/	25/2015	
	OVIDER OR SUPPLIER ONG TERM CARE FA	ACILITY	302 N B	RESS, CITY, STA OTKIN , KS 67009	TE, ZIP CODE	.		
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F 253	by 3 inches at the w door contained scra door. 9.) The curved floor contained 28 areas from 8 to 24 inches 200 HALL 1.) Seven resident rescrapes along the w doors. 2.) Silver colored part doors contained discripted in the contained discripted from the contained black inches. 4.) The common live with a silver panel, w door jam and contained scrape in the paint. 5.) The residents contained in the paint. 5.) The residents contained a front part of the contained a front part of	idest width. The bathroopes across the width of the towall floor covering with cracks ranging in significant in length. Toom doors contained idth of the lower portion anels on the dining room colorations. In panel on the activity room colored areas, and the doscrapes along the lower ing area, contained a dowith discolorations and the ned an approximate 10 in common living area contained an approximate 10 in common living area contained in inches. In gunit, in the hallway, nel with multiple black	the ze ze of the more not	F 253				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	LE CONSTRUCTION	1, 7	(X3) DATE SURVEY COMPLETED	
		17E534		B. WING		11/2	25/2015	
	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
ATTICA L	ONG TERM CARE FA	CILITY	302 N E ATTICA	OTKIN A, KS 67009				
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F 253	wall beneath the light approximately 8 by 8 9.) An outside area was room contained 2 me frames, 2 black pallet accumulation of brancarea unsightly. Maint black structures were and was unsure of who was unsure of who was unsure of who was unsure of who taknow why the lau 10.) The curved floor contained 14 areas was from 8 to 24 inches in the common residual recliner with worn was a recliner with worn was recliner with a second recliner with a upholstering approximately 10 by second recliner contained the upholstery. 2.) A resident room areas approximately inches. The facility policy for updated July 2015, a whenever it is required. The facility failed to make the comfortable interior for in these resident areas.	contained scrapes on the fixture, measuring inches. within view of 2 resident stal circular laundry cart to type structures, and an ches and leaves, making enance staff D stated the used as planter elevate there to store them, and andry carts were in the art to wall floor covering with cracks ranging in sign length. idents' living area containly upholstery 4 inches in 3 areas and an area of worn vinyl mately 18 by 10 inches. The darm rests with cracks wall contained 6 scrape 1/2 by 1/2 inch and 2 by 1/2 inch	districtions did area.	F 253				
F 279 SS=D	(//			F 279				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			1, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 279	F 279 Continued From page 6			F 279			
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's						
	medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.						
	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).						
	This Requirement is not met as evidenced by: The facility reported a census of 47 residents with 22 selected for review, including one reviewed fo urinary incontinence. Based on observation, interview and record review, the facility failed to develop the care plan for 1 selected resident to include an individualized toileting plan. (#2)		s with ed for , d to				
	Findings included:						
	(minimum data set), resident was assess interview for mental severe cognitive det assistance with dres	t #2's Quarterly MDS dated 10-5-15, revealed sed with a BIMS (brief status) score of 4 indica ficit, required extensive ssing, toilet use and persidependent with ambulati	ting				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
17E534			B. WING		11	/25/2015		
NAME OF PROVIDER OR SUPPLIER ATTICA LONG TERM CARE FACILITY			302 N E	RESS, CITY, STA BOTKIN , KS 67009	TE, ZIP CODE			
PREFIX (EACH DEFICIENCE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
incontinent of u received a diure wandering 1-3 of the annual MD resident with a cognitive deficit with toilet use, of toileting with current toileting incontinent of u. The CAA (care incontinence, or resident as free staff advised to the resident did and changing in also take him/h. The care plan, change the resident to use needed, The resident to use needed, The resident to use needed, The resident to the resident was on however, there documented. Review of the till 9-28-15 through experienced incomplets.	fied to the field to fie	the resident as frequently with no current toileting part had rejection of care of the look back period. It ted 2-2-15, assessed the score of 3 indicating set in the look back period. It ted 2-2-15, assessed the score of 3 indicating set in the look back period. It ted 2-2-15, assessed the standard was frequently assessment) for urinary 2-3-15, assessed the sy incontinent of urine are nim/her to use the toilet of staff to assist with toilet nent products and would to the toilet at times. It to the toilet at times. It is incontinence products are. Staff advised to could be sufficiently 2 hours and a standard was able to take the tat times, but often for seep the bathroom light plan, dated 10-13-15, it is room, revealed the heduled toileting plan, no individualized plan and experienced the residence episodes on 9-28-am and experienced	olan, and eevere ce trial a and eting d and ue the as rgets, on at ent	F 279				

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ PLAN OF CORRECTION IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	17E534			B. WING		11/2	11/25/2015	
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F 279	incontinence 11:00 a incontinence on 9-25 pm and 2:00 pm on 9 experienced incontine the 3 day observation. The quarterly nursing 9-29-15, assessed to cognitive ability to use memory and inability toileting tasks. Staff toilet and the resider often was already we observation, on 11-1 the resident ambulate his/her room. The resident ambulate his/her room. The resident ambulate him/herself, but was not always cooperate linterview, on 11-18-1 nursing staff E, reveal incontinent of urine a could be implemented stubborn at times, and pants when wet. Observation, on 11-2 are staff H, revealed the resident seated in the resident seated in the resident seated in the resident seated in the resident ambulating this/her pants wet in the linterview, on 11-23-2 care staff H, revealed the revenue of the resident seated in the resident seated in the resident ambulating this/her pants wet in the linterview, on 11-23-2 care staff H, revealed the revenue of the revenue	im 9-28-15 and 9-30-15 at 12:00 pm and 1: 9-28-15. The resident lence episodes throughons. g assessment, dated the resident with impaire se the toilet due to declire to remember day to da are to remind the resident will urinate in the toilet et. 17-15 at 8:08 am, reveal ed from the dining room esident's pants were well to at 9:30 am, with direct dincontinent at times, and with staff. 15 at 9:45 am, with licental ed the resident was and doubted if a toileting ed as the resident was and staff would change him observation revealed from the dining room eating mobservation revealed from the dining room with the d	out define in y ent to	F 279				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM					(X3) DATE SURVEY COMPLETED			
		17E534		B. WING			25/2015	
	OVIDER OR SUPPLIER ONG TERM CARE FA	CILITY	302 N B	ADDRESS, CITY, STATE, ZIP CODE N BOTKIN ICA, KS 67009				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 279	meals are paid for. needs to be toileted, toileted before break Interview, on 11-23- staff P, revealed he/ incontinence the res evaluated the voidin- looked through the of identification of the inthink the resident had Interview, on 11-23- administrative nursing resident was not on should remind the resident was not on should remind	Staff H stated the reside and thought he/she was fast, but was not sure. 15 at 4:32 pm, with nurs she did not know what to ident had, and usually g diary for incontinence thart for physician incontinence. Staff P did d a toileting plan. 15 at 1:23 pm, with ing staff B, revealed the a toileting plan, and the esident to toilet. Turinary incontinence, resident to help determine. The different types of efined as urge, stress, insient and overactive ontinence and a care plat followed for the ed. develop an individualize assist with restoring or unction for this resident.	ing ype of and not staff evised the nixed,	F 279				
	RESTORE BLADDE Based on the reside assessment, the fac resident who enters indwelling catheter is resident's clinical co- catheterization was		at nt	F 315				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED			
	ME OF PROMISED OR CHERWISE			B. WING	B. WING		25/2015			
NAME OF PR	ME OF PROVIDER OR SUPPLIER ST			RESS, CITY, STAT	E, ZIP CODE	•				
ATTICA LO	ONG TERM CARE FAC	CILITY	302 N E	302 N BOTKIN						
			ATTICA	, KS 67009						
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F 315	Continued From page 10			F 315						
	treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.									
	This Requirement is not met as evidenced by: The facility reported a census of 47 residents with 22 selected for review, including one reviewed for urinary incontinence. Based on observation, interview and record review, the facility failed to provide an individual toileting program for the one (#2) resident reviewed for incontinence. Findings included:									
	- Review of resident #2's Quarterly MDS (minimum data set), dated 10-5-15, revealed the resident was assessed with a BIMS (brief interview for mental status) score of 4 indicating severe cognitive deficit, required extensive assistance with dressing, toilet use and personal hygiene and was independent with ambulation. The MDS identified the resident as frequently incontinent of urine with no current toileting plan, received a diuretic and had rejection of care and wandering 1-3 days of the look back period.									
	The annual MDS, dated 2-2-15, assessed the resident with a BIMS score of 3 indicating severe cognitive deficit, required extensive assistance with toilet use, personal hygiene, and had a trial of toileting with no improvement, was not on a current toileting program and was frequently incontinent of urine. The CAA (care area assessment) for urinary incontinence, dated 2-3-15, assessed the resident as frequently incontinent of urine and staff advised to cue him/her to use the toilet and the resident did allow staff to assist with toileting									

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and also The chass reserved him and night following the common of the his common of	so take him/herself in the care plan, update the resident's resist with perineal cassident to use the toil reded, The resident method staff advised to ke to the toil reded, The resident and staff advised to ke to the toil reded, The resident's resident was on a school redeal of the three decays of the thr	tent products and would to the toilet at times. and 10-8-15, advised state incontinence products are. Staff advised to cullet every 2 hours and at was able to take at at times, but often for eep the bathroom light colan, dated 10-13-15, in a room, revealed the leduled toileting plan, to individualized plan and experienced are episodes on 9-28-m and experienced an 9-28-15 and 9-30-15, 15 at 12:00 pm and 1:-28-15. The resident ence episodes throughout and the resident with impaire at the toilet due to decline to remember day to day are to remind the resident will urinate in the toilet will urinate in the toilet.	off to and see the see	F 315				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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F 315	Continued From page	e 12		F 315				
F 315	Observation, on 11-18 the resident in the din at 9:00 am, the resider room and toileted self. Interview, on 11-18-19 care staff Q, revealed him/herself. Interview, on 11-18-19 care staff R, revealed him/herself, but was in not always cooperate. Interview, on 11-18-19 nursing staff E, reveal incontinent of urine at could be implemented stubborn at times, and pants when wet. Observation, on 11-23 the resident seated in breakfast. At 9:53 and resident ambulating fin his/her pants wet in the Interview, on 11-23-19 care staff H, revealed dining room table, unit meals are paid for. So needs to be toileted, at toileted before breakfast.	8-15 at 8:15 am, reveal ling room eating breakfent ambulated to his/he f. 5 at 9:15 am, with direct the resident toileted 5 at 9:30 am, with direct the resident toileted 6 at 9:45 am, with licen led the resident was and doubted if a toileting d as the resident was d staff would change him to baservation revealed room the dining room with the resident will sit at the resident will	ast, r at did did sed plan s ed dithe the er the er the ent s	F 315				
	staff P, revealed he/s incontinence the resid	he did not know what ty dent had, and usually diary for incontinence	ype of					

Printed: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 17E534 B. WING 11/25/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER ATTICA LONG TERM CARE FACILITY **302 N BOTKIN ATTICA, KS 67009** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 315 F 315 Continued From page 13 identification of the incontinence. Interview, on 11-23-15 at 1:23 pm with administrative nursing staff B, revealed the resident was not on a toileting plan, and the staff should remind the resident to toilet. The facility policy for urinary incontinence, revised 8/2014, advised staff to conduct and incontinence assessment to help determine the type of incontinence. The different types of incontinence were defined as urge, stress, mixed, functional deficit, transient and overactive bladder/overflow incontinence and a care plan will be developed and followed for the incontinence identified. The facility failed to provide an individualized toileting program to assist with restoring or improving bladder function for this resident. F 329 483.25(I) DRUG REGIMEN IS FREE FROM F 329 SS=D UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
	17E			B. WING		11/2	25/2015	
NAME OF PR	NAME OF PROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE	•		
ATTICA L	ONG TERM CARE FA	CILITY	302 N B ATTICA	OTKIN A, KS 67009				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	Continued From page 14			F 329				
	drugs receive gradua behavioral intervention	I dose reductions, and	ese	,				
	The facility identified and The sample included reviewed for unnecess Based on observation interview the facility faunnecessary medicat monitoring for 2 of the including; (#8) with an	sary medication usage. n, record review, and ailed to ensure no ions with adequate e 5 sampled residents nti-hypertensive medica edications and for (#45) re to assess for nistration of PRN (as	s.					
	Findings included: - The physician orders, dated 11/2/15, revealed resident #8 was admitted to the facility on 3/8/14 with the following diagnoses including: hypertension (elevated blood pressure), major depressive disorder (major mood disorder), restlessness and agitation. The CAA (care area assessment), dated 6/29/15, for cognition, documented the resident had times		9/15, imes					
	someone to sit or wal time. The care plan dated 9	e anxious and would wa k next to him/her the er 9/23/15, documented re e medication, the staff v	elated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		17E534		B. WING		11/.	25/2015	
	OVIDER OR SUPPLIER ONG TERM CARE FA	CILITY	302 N E	RESS, CITY, STA BOTKIN J, KS 67009	ΓΕ, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	IATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	to check the resident resident received Tek medication), 300 mg hypertension, and inst the resident 's systolic than 100. However, the physicia Tekturna, 300 mg, 1 k Hold if the systolic blo 100 or a pulse less the would not know if the medication if the bloo obtained or document administration. Review from Feb, 202015, of the only blood documented, with the revealed the staff failed blood pressures on 2 and 11/4/15. The recast owhy staff failed blood pressure readin. On 11/16/15 at 3:30 phis/her room, in a who groomed, and without On 11/23/15 at 1:31 pstated the resident's k were usually taken with administration but the to document those bloobtained. On 11/23/15 at 1:37 pstaff A stated the faciliall medication/vital signal and instruction of the facilial medication/vital signal and instruction in the facilian medication/vital signal and instruction in the facilian medication/vital signal and instruction in the facilian medication	's vital signs weekly. The turna (anti-hypertensive (milligrams), daily, for structed staff to not give it blood pressure was less that an ordered on, 3/30/15, by mouth, every day at an od pressure is less that an 50. Therefore, the sty should hole this dipressure/pulse were sted prior to the medicate of the obtain even weekly vital and to obtain even weekly 15/15, 5/9/15, 10/22/15 ord lacked any explanate to obtain the resident 's angs on these days. D.m., the resident sat in elelchair and appeared to behaviors. D.m., direct care staff Solood pressures and put the staff of the sta	e it if ess noon. In staff not ion 23, signs by 5, ation s well lise iled when sing for a sign of the sing of the sing for a sign of the sing for a sign of the sing o	F 329				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUF IDENTIFICATION 17				E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E534		B. WING		11.	/25/2015	
NAME OF PROVIDER OR SUPPLIER ATTICA LONG TERM CARE FACILITY			302 N B	RESS, CITY, STAT OTKIN , KS 67009	E, ZIP CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 329	vitals for this resider medication to ensur pulse were within the physician. Howe have vital signs obta explained the blank should not be left blasigns and/or blood pon the documentation. The facility policy, defined medication monitoring will collaborate with parameters such as medications and the effect of the following the effect of the following resident received are for 7 days. The CAA (care area for psychotropic medications) routine depression. The readepression with declaration and sad thoughts of also had just started (anti-anxiety medication anxiousness.	nt before administering the the blood pressure and e parameters as ordered ever, all residents were to ained weekly. Staff A furthareas on the documenta ank. There should be vibressures in the blank spon. ated October 2014, for ang, documented the facilithe prescriber to identify a pulse and BP for monitoried and the prescriber to identify a pulse and BP for monitoried action combinations the consequences and futiveness of medications. Sident's significant changes a set), dated 6/29/5, reveating the prescriber with a moor mild mood/depression. In antidepressant medication, documented a sion and the resident curicum and Remeron (anti-depression and the resident curicum and Remeron (anti-depression).	d by bother ation tal saces lity bother ation tal saces li	F 329				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
17E\$		17E534		B. WING		11/25/2015		
NAME OF PR	NAME OF PROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
ATTICA LONG TERM CARE FACILITY			302 N E ATTICA	SOTKIN A, KS 67009				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329	Continued From page 17			F 329				
	resident experienced	other behaviors, not						
	directed towards other	ers, but these occurred	daily.					
	use of psychotropic management of the physician ordered (anti-depressant), 1 b major depressive discontinuous depression.	d on 6/16/15, Remeron by mouth every evening order. d on 6/29/15, Buspirone), 10 mg, 1 by mouth tw	ent. al, ivan, and ed to of for a					
	daily for agitation and restlessness. The physician ordered on 7/30/15, Ativan (anti-anxiety), 0.5 mg, 1/2 tablet, by mouth three times daily for anxiety.		nree					
	Review of the facility documentation for monitoring of the resident's behaviors included: withdrawal, decreased appetite, social isolation, unable to sit for any length of time, and restlessness.							
	of August, 2015 revea	or monitoring for the mo aled 17 blank spaces fo s behaviors monitored.						
	Review of the behavior	or monitoring for the mo	onth					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIED IDENTIFICATION NUMBER OF CORRECTION (X1) PROVIDER/SUPPLIED IDENTIFICATION (X1) PROVIDER				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E534		B. WING		11/25/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	-	
ATTICA L	ONG TERM CARE FA	CILITY	302 N B	OTKIN			
			ATTICA	, KS 67009			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI	ON (X5	
PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOUL		
TAG	OR LSC ID	DENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	
F 329				F 329			
	•	revealed 48 blank space	es for				
	the documented 6 be	enaviors monitored.					
	Review of the behavi	or monitoring for the mo	onth				
		ealed 25 blank spaces					
	the documented 6 be	-					
	Review of the behavi	or monitoring from					
	November 1 through	the 23, 2015 revealed 2	29				
	•	documented 6 behavior	rs				
	monitored.						
	On 11/18/15 at 1:05 p	o.m., licensed nursing s	taff G				
	stated the behaviors	were documented on the	ne				
		ne nurses as well as on					
		ram), in care tracker (n					
	-	mentation of cares) by					
		ng assistant). If a resid					
	_	or, the CNAs would not	-				
		or. Licensed nursing stansure of why there were					
		behavior monitoring sh					
		ned this could be times					
	-	cy nursing staff working					
		not be aware of the ne					
	complete the residen	t's behavior sheets.					
		o.m., administrative nur					
		staff were expected to f					
		during each shift. He/sh	ne				
		not doing their jobs by resident's behavior sho	aete				
	leaving bialiks on the	, residents benaviol Sil					
	The facility policy, da	ted October 2014, for					
		g documented the facili	ty will				
		iveness of the medication	•				
	including the target b						
	indicating the adminis	stration of the medication	on.				
	The facility failed to m	nonitor this resident's bl	ood				

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E534		B. WING		11/2	25/2015
	OVIDER OR SUPPLIER ONG TERM CARE FA	CILITY	302 N B	RESS, CITY, STA OTKIN , KS 67009	TE, ZIP CODE	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	pressure/pulse, and t received anti-hyperte antianxiety medicatio consequences with u	argeted behaviors, whil insive, anti-depressant a ins, to ensure no advers innecessary medication	and se s.	F 329			
	- The signed physician orders, dated 11/2/15, of Resident #45, documented the resident admitted on 4/3/15, with the following diagnoses including; dementia -(progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, delirium due to known physiological condition (sudden severe confusion, disorientation and restlessness), alzheimers's disease (progressive mental deterioration characterized by confusion and memory failure), and pain.						
	The Quarterly MDS (minimum data set), dated 7/6/15, revealed the resident had a BIMS (brief interview for mental status) score of 3, indicating severely impaired cognition. The resident did have delusions, no behavioral symptoms, and no rejection of care or wandering. The resident was occasionally incontinent of urine and bowel. The resident pain assessment interview revealed no pain.		rief ating d nd no was The				
	revealed the resident pain assessment inte assessment indicated sounds, vocal compla movement or posture	ge MDS, dated 9/28/15, was unable to answer erview, and the staff d the resident had non-vaints, and protective books to indicate pain. Pain ed daily on the 7 day loc	verbal dy or				
		assessment) was dated e CAA revealed the res					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	17E53			B. WING		11/25/2015		
NAME OF PROVIDER OR SUPPLIER ST		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE				
ATTICA LONG TERM CARE FACILITY			302 N BO	OTKIN KS 67009				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 329	experienced confusion resident had a fall who pelvis. The resident reexpression and though and outbursts of anxiet Percocet (narcotic), a solution/ a narcotic) for The physician orders 7/22/15 Ativan 1 mg ((oral) PRN (as needed diseases with behavious 9/24/15 Morphine solution of the percocet 5-32 needed for pain. Standing order for Millias needed for pain. Standing order for Millias needed for constipmovement in 2-3 days 1-2 per rectum. Review of the Septemadministration review Ativan 1 mg (milligrane effectiveness of the matication 20 times.) Review of the Octobe staff administered Ative effectiveness of the madministered the morph and lacked effectiveness of the madministered the morph	n and paranoia. The ich resulted in a fractur eceived Mirtazapine for alths, Ativan for aggress ety and paranoia, and nd Roxanol (morphine or pain. included the following: milligram) every 4 hourd of for dementia in other oral disturbance ution 20 mg/5 ml (millility hours as needed for page 25 mg every 4 hours as alk of Magnesia 45 ml or	rs ad ion rs po er ter), relivic stered cked the dd dd cked the dd	F 329				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
17E		17E534		B. WING		11/25/2015		
NAME OF PROVIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ATTICA L	ONG TERM CARE FA	CILITY	302 N B ATTICA	OTKIN ., KS 67009				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 329	Continued From page	e 21		F 329				
	times, and lacked folloof the medication 16 t	ow-up of the effectivend times.	ess					
	Review of the November 2015 MAR, evidenced staff administered the prn Percocet and prn Ativan on 11/8/15 and lacked follow-up of the effectiveness of the medication.							
	Furthermore, review of the Bowel movement records from 8/25/15 to 11/23/15, revealed the resident had a bowel movement on 9/9/15, and lacked another bowel movement until 9/16/15 (6 days). The resident lacked a bowel movement from 9/25/15 to 10/1/15 (6 days), lacked a bowel movement from 10/3/15 until 10/9/15 (6 days), lacked bowel movement from 10/3/15 to 11/4/15 (4 days) (had one on the 4th) and lacked bowel movement from 11/4/15 to 11/11/15 (9 days), and lacked bowel movement from 11/4/15 to 11/13/15 to 11/23/15 (9 days).							
	The MAR revealed no November, 2015	o laxative was given in						
	stated the resident ha administer pain medic the resident had no b then should administe	2 PM, direct care staff had pain, and he/she did cation which was effectioned movement in 2 dater the milk of magnesiaff should administer the	ive. If ys, and					
	staff G, stated staff sh follow-ups for effective MAR. Licensed nursin	23 PM, licensed nursing nould document the properties on the back of the staff G verified that the tation of the effectivents administered.	ie he					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E534		B. WING		11/	25/2015
				ESS, CITY, STA	TE, ZIP CODE		
ATTICA LONG TERM CARE FACILITY			302 N BO ATTICA,	KS 67009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	Continued From pag	je 22		F 329			
	nursing staff B, verification the prn's on the back documentation expect prn medication given a bowel movement in receive Milk of magnexpected to run a regive the list of those laxative to the medication. On 11/23/2015 at 11: G, stated if a residen movement for 3 days administer the milk of did not have results, bowel movement, the for further orders. On 11/23/2015 at 3:1 staff C, verified the breferred to the standing that the standing staff chart the medications. The conhe/she did randomly for effectiveness. The facility's policy, chabits, revealed the latest and so well as the latest and the la	cted was to follow up or . If the resident did not had a days, the resident wesia. The nurses were cort every night, and wo residents who needed a ation aide to administer 30 am, licensed nursing t did not have a bowel	n any have ould uld a . g staff ent no stiffied ursing icy in. lent r the re MAR				
	protocol as appropria physician for the elde	shift and initiate the bow ate. A laxative ordered be or given if the elder had the previous 6 eight hou	no the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
				25/2015				
	E OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
	ONG TERM CARE FA	CILITY	302 N E		TE, ZIF GODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	shifts (3 days). Follow elder does not have a the protocol. Furthern medication monitoring the effects of medicat monitored to assess t medication therapy. Emedication administe to his/her clinical need be documented on the progress note of the eadministration. The facility failed to mof prn medication for resident with pain and	with the bowel protocol if the BM after the first step more, the facility's go, dated 10/2014, reveal ions on elders are the effectiveness of the effectiven	of aled ding will e	F 329				
F 371 SS=F	STORE/PREPARE/SI The facility must - (1) Procure food from considered satisfacto authorities; and (2) Store, prepare, dis under sanitary conditions. This Requirement is The facility had a cen on observation, intervifacility failed to store,	sources approved or ry by Federal, State or stribute and serve food	oy: ased , the id	F 371				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
i i i i i i i i i i i i i i i i i i i							OOMI LETES	
		17E534		B. WING		11/2	5/2015	
	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
ATTICA L	ONG TERM CARE FA	CILITY	302 N E ATTICA	KS 67009				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 371	Continued From page Findings included: - During a tour of the 11:40 a.m., with dieta following items/areas 1.) A drawer contained which rested on a dirt. 2.) A drawer which could had a build-up of dries around the inside edge drawer also held a material spatula was mistaround the edges. 3.) A drawer contained sharpeners and a wook held a build-up of food substance. One of the covered in rust and the scratched, making it at 4.) A drawer which he had a metal rusted be resting on the rusted of the on food.	kitchen on 11-18-15 at ry manager staff M, the of concern were noted: ed 8 salad dressing scory paper towel. Intained rubber spatular of food crumbs/particles ges of the drawer. This arinating brush with placed in the drawer soils on the bristles. A large ssing the protective finished measuring cups, 2 k oden rolling pin all of wild debris and a sticky exhife sharpeners was an uncleanable surface. eld toothpicks and lubrication with food debris bottom.	esticed shing nife hich	F 371		APPROPRIATE		
	food.	nixer stand had dried or the kitchen had food d d foot pedals.						
		ge contained food for the bottom						

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	17E534 B. WING 11/25/2		5/2015				
NAME OF PROVIDER OR SUPPLIER ATTICA LONG TERM CARE FACILITY		CILITY	302 N B	NESS, CITY, STA OTKIN , KS 67009	TE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 371	Continued From page	 e 25		F 371			
F 371	9.) A shelf held plastidirt across it. 10.) Three cooling rate a black substance. 11.) Five, 1 dozen cut away ready for use at 12.) Five, small cook dark substance around corners. 13.) The toaster had inside. 14.) A notebook, hold a heavy build-up of for the outside cover. On 11-23-15 at 10:17 stated, he/she was the responsible for the own He/she stated there we that did not mean ever the did not mean ever the stated there we would need to the consuring the cleaning properly. The facility policy for edated 2/15, document prepare, distribute an conditions to ensure the substance of the state of the consurer to the state of the consurer to the state of the	ic food container lids with cks held a heavy build- pecake pans, had been and held food particles in the sheets had a build-up and the inside edges and a build-up of crumbs or the did the inside edges and a build-up of crumbs or the weekly menus, and debris and grease of the strong always was dorn to start following up and the facility will store to serve food under san that proper sanitation and the strong always was dorn the strong proceduted the facility will store the serve food under san that proper sanitation and the strong proceduted the facility will store the strong proceduted the strong	put side. p of a n the had over or M e, but he. lie	F 371			
	food handling practice foodborne illness is a members are respons cleaning schedule da scheduled for that day	es to prevent the outbre ttained continuously. S	eak of taff				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED		
		17E534	17E534 B. WING 11/25/20		25/2015				
	OVIDER OR SUPPLIER ONG TERM CARE FA	CILITY	302 N B	ET ADDRESS, CITY, STATE, ZIP CODE 102 N BOTKIN TTICA, KS 67009					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 371	cleaned daily. The facility failed to solve food under sanitary of		e	F 371					
	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.		d s to	F 428					
	The facility identified The sample included reviewed for unnece Based on observation interview the facility to identify the facility adequate monitoring residents including; (medication and antifor (#45) with constitor effectiveness of a needed) medications	a not met as evidenced la a census of 47 resident 22 residents, with 5 ssary medication usage on, record review, and pharmacist consultant fastaff failure to obtain for 2 of the 5 sampled (#8) with anti-hypertensic psychotic medications a pation and failure to assert administration of PRN (as administered.	ts. ailed ve and ess						
	Findings included: - The physician order	ers dated 11/2/15 reve	aled						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E534		B. WING		11/25/	
ATTICA LONG TERM CARE FACILITY		302 N E	RESS, CITY, STA BOTKIN J, KS 67009	TE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	
F 428	resident #8 was admi with the following diag hypertension (elevate depressive disorder (restlessness and agit The CAA (care area a for cognition, docume when he/she became someone to sit or wal time. The care plan dated 9 to high blood pressure to check the resident resident received Tek medication), 300 mg hypertension, and inst the resident 's systolic than 100. However, the physicia Tekturna, 300 mg, 1 the Hold if the systolic blo 100 or a pulse less the would not know if the medication if the blood obtained or documen administration. Review from Feb, 20: 2015, of the only blood documented, with the revealed the staff failed blood pressures on 2 and 11/4/15. The recast to why staff failed blood pressure reading the staff failed blood pressure reading	tted to the facility on 3/8 gnoses including: an ordered on, 3/30/15, by mouth, every day at 100 pressure was less that an 50. Therefore, the sy should hole this d pressure/pulse were sted prior to the medication obtain even weekly vitaled to obtain even weekly ord lacked any explanate to obtain the resident 's sylvana and the syl	or 9/15, imes nt ntire elated were ihe ess noon. in staff not ion 23, signs by 5, stion s	F 428			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l` ′	E CONSTRUCTION	(X3) DATE SU COMPLE	
	17E534			B. WING		11/25/2015	
ATTICA LONG TERM CARE FACILITY 303			STREET ADDR 302 N BO ATTICA,		TE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	his/her room, in a wh groomed, and without On 11/23/15 at 1:31 stated the resident's were usually taken wadministration but the to document those by obtained. On 11/23/15 at 1:37 staff A stated the fact all medication/vital sexplained he/she wo vitals for this resident medication to ensure pulse were within the the physician. Howe have vital signs obtatexplained the blank should not be left blastigns and/or blood pon the documentation. The facility policy, damedication monitoring will collaborate with a parameters such as medications and me pose a risk for advermonitoring the effect. Furthermore, the resident with a B mental status) score impaired cognition. It is score of 6 indicating	p.m., direct care staff S blood pressures and puvith the medication en explained the staff fallood pressures/pulses v p.m., administrative nurility had standing orders igns parameters. Staff A buld expect the staff to take the blood pressure and exparameters as ordered exer, all residents were to ined weekly. Staff A furt areas on the documental ank. There should be vitressures in the blank sp	alse iiled when sing for ake he d d by her ation tal acces iity oring hat or	F 428			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 17E534 B. WING 11/25/2						
						11/2	5/2015
NAME OF PR				RESS, CITY, STA	TE, ZIP CODE		
		302 N B ATTICA	OTKIN , KS 67009				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	Continued From page 29			F 428			
	for psychotropic medical diagnosis of depression received Lexapro and medications) routinely depression. The reside depression with decreand sad thoughts of balso had just started (anti-anxiety medicatifor anxiousness. The quarterly MDS, diresident experienced directed towards other than the care plan dated suse of psychotropic management of the care plan dittle received medications and Remeron for depagitation at times. Institutions	dent experienced signs eased appetite, withdra being down The resider on Buspar and Ativan ons) to be taken as nee ated 9/21/15, revealed	rently sant of wal, nt eded the daily. ee ent. al, ivan, and ed to				
	The physician ordered on 3/30/15, Lexapro (anti-depressant), 20 mg, 1 by mouth at noon for a major depressive disorder.		n for				
	· ·	d on 6/16/15, Remeron y mouth every evening order.					
		d on 6/29/15, Buspirone , 10 mg, 1 by mouth tw restlessness.					
	The physician ordered	d on 7/30/15, Ativan					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
and Plan of Correction identification num		i.c.					
		17E534		B. WING		11/2	5/2015
NAME OF PR			STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ATTICA LONG TERM CARE FACILITY		302 N B ATTICA	OTKIN ., KS 67009				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	1 0			F 428			
	(anti-anxiety), 0.5 mg, 1/2 tablet, by mouth three times daily for anxiety.						
	Review of the facility documentation for monitoring of the resident's behaviors included: withdrawal, decreased appetite, social isolation, unable to sit for any length of time, and restlessness.						
	Review of the behavior monitoring for the month of August, 2015 revealed 17 blank spaces for the documented 6 various behaviors monitored. Review of the behavior monitoring for the month of September, 2015 revealed 48 blank spaces for the documented 6 behaviors monitored. Review of the behavior monitoring for the month of October, 2015 revealed 25 blank spaces for the documented 6 behaviors monitored. Review of the behavior monitoring from November 1 through the 23, 2015 revealed 29 blank spaces for the documented 6 behaviors monitored. On 11/18/15 at 1:05 p.m., licensed nursing staff G stated the behaviors were documented on the behavior sheets by the nurses as well as on the kiosk (computer program), in care tracker (nurse aides computer documentation of cares) by the CNAs (certified nursing assistant). If a resident was having a behavior, the CNAs would notify the nurses of the behavior. Licensed nursing staff G stated he/she was unsure of why there were empty spaces on the behavior monitoring sheets. Staff G further explained this could be times when the facility had agency nursing staff working and the agency staff may not be aware of the need to complete the resident's behavior sheets.						

IN OF CORRECTION IN IDENTIFICATION NUMBER			` '		(X3) DATE SURVEY COMPLETED	
	17E534		B. WING		11/2	5/2015
	ACILITY	302 N B	OTKIN	E, ZIP CODE	•	
(EACH DEFICIENCY MU	OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
On 11/23/15 at 1:37 staff A explained the the behavior sheets stated the staff were leaving blanks on the The facility policy, deficition monitor for the effect including the target indicating the adminstrated that he/she dobtaining blood presecretain medications parameters. Staff U that was being done Furthermore, he/she review the residents on the residents. He nurses notes before medications or before (gradual dose reductions or before) (gradual dose reductions or the facility pharmactirregularity of the facility pharmac	p.m., administrative nure staff were expected to form during each shift. He/she not doing their jobs by the resident's behavior she atted October 2014, for any documented the facilitativeness of the medication behaviors/conditions distration of the medication p.m., consultant staff U to the post of the staff source or pulses before ging, which would have order explained he/she assume if it was ordered that was estated that he/she does to behavior monitoring showever, staff U did review making adjustments on the recommending GDRs of the staff to the physician's of the physician	fill out ne eets. Ity will ons, on. If are ving red ned ay. s not eets w the eets w the eets w the eets w the eet sor	F 428			
	OVIDER OR SUPPLIER ONG TERM CARE FA SUMMARY (EACH DEFICIENCY ML OR LSC I Continued From pa On 11/23/15 at 1:37 staff A explained the the behavior sheets stated the staff were leaving blanks on the The facility policy, d medication monitori monitor for the effect including the target indicating the admin On 11/23/15 at 1:31 stated that he/she d obtaining blood presion certain medications, parameters. Staff U that was being done Furthermore, he/she review the resident's on the residents. He nurses notes before medications or before (gradual dose reduct after a new medicat The facility pharmac irregularity of the fact monitor this residen targeted behaviors, anti-hypertensive, a medications, to ensi- with unnecessary medicated. The signed physic Resident #45, documents	OVIDER OR SUPPLIER ONG TERM CARE FACILITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION) Continued From page 31 On 11/23/15 at 1:37 p.m., administrative nur staff A explained the staff were expected to the behavior sheets during each shift. He/sl stated the staff were not doing their jobs by leaving blanks on the resident's behavior shift. The facility policy, dated October 2014, for medication monitoring documented the facilimonitor for the effectiveness of the medicationiculuring the target behaviors/conditions indicating the administration of the medication. On 11/23/15 at 1:31 p.m., consultant staff U stated that he/she does not review if the stated that he/she does not review if the stated that was being done if it was ordered that was ordered that was being done if it was ordered that was ordered that was ordered that wa	OVIDER OR SUPPLIER ONG TERM CARE FACILITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 On 11/23/15 at 1:37 p.m., administrative nursing staff A explained the staff were expected to fill out the behavior sheets during each shift. He/she stated the staff were not doing their jobs by leaving blanks on the resident's behavior sheets. The facility policy, dated October 2014, for medication monitoring documented the facility will monitor for the effectiveness of the medications, including the target behaviors/conditions indicating the administration of the medication. On 11/23/15 at 1:31 p.m., consultant staff U stated that he/she does not review if the staff are obtaining blood pressure or pulses before giving certain medications, which would have ordered parameters. Staff U explained he/she assumed that was being done if it was ordered that way. Furthermore, he/she stated that he/she does not review the resident's behavior monitoring sheets on the residents. However, staff U did review the nurses notes before making adjustments on medications or before recommending GDRs (gradual dose reduction) to the physician's or after a new medication was started. The facility pharmacist failed to identify the irregularity of the facility staff failure to adequately monitor this resident's blood pressure/pulse, and targeted behaviors, while the resident received anti-hypertensive, anti-depressant and antianxiety medications, to ensure no adverse consequences	OVIDER OR SUPPLIER DNG TERM CARE FACILITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 F 428 The facility policy, dated October 2014, for medication monitoring documented the facility will monitor for the effectiveness of the medications, including the target behaviors/conditions indicating the administration of the medication. On 11/23/15 at 1:31 p.m., consultant staff U stated that he/she does not review if the staff are obtaining blood pressure or pulses before giving certain medications, which would have ordered parameters. Staff U explained he/she assumed that was being done if it was ordered that way. Furthermore, he/she stated that he/she does not review the resident's behavior monitoring sheets on the residents. However, staff U did review the nurses notes before making adjustments on medications or before recommending GDRs (gradual dose reduction) to the physician's or after a new medication was started. The facility pharmacist failed to identify the irregularity of the facility staff failure to adequately monitor this resident's blood pressure/pulse, and targeted behaviors, while the resident received anti-hypertensive, anti-depressant and antianxiety medications, to ensure no adverse consequences with unnecessary medications.	DOUDER OR SUPPLIER THE 534 SITE TADDRESS. CITY, STATE, ZIP CODE 302 N BOTKIN ATTICA, KS 67099 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY) OR LSC IDENTIFYING INFORMATION) COntinued From page 31 Continued From page 31 On 11/23/15 at 1:37 p.m., administrative nursing staff A explained the staff were expected to fill out the behavior sheets during each shift. He/she stated the staff were not doing their jobs by leaving blanks on the resident's behavior sheets. The facility policy, dated October 2014, for medication monitoring documented the facility will monitor for the effectiveness of the medications, including the target behaviors/conditions indicating the administration of the medication. On 11/23/15 at 1:31 p.m., consultant staff U stated that he/she does not review if the staff are obtaining blood pressure or pulses before giving certain medications, which would have ordered parameters. Staff U explained he/she assumed that was being done if it was ordered that way. Furthermore, he/she stated that the/she does not review the resident's behavior monitoring sheets on the residents. However, staff U did review the nurses notes before making adjustments on medications or before recommending GDRs (gradual dose reduction) to the physician's or after a new medication was started. The facility pharmacist falled to identify the irregularity of the facility staff failure to adequately monitor this resident's blood pressure/pulse, and targeted behaviors, while the resident received anti-hypertensive, anti-depressant and antianxiety medications, to ensure no adverse consequences with unnecessary medications. - The signed physician orders, dated 11/2/15, of Resident #45, documented the resident admitted	The state of the staff were not doing their jobs by leaving blanks on the resident's behavior sheets. The facility policy, dated October 2014, for medication monitoring documented the facility will monitor for the effectiveness of the medications, including the larget behavior/sconditions indicating the administration of the medication. On 11/23/15 at 1:31 p.m., consultant staff U stated that he'she does not review if the staff are obtaining blood pressure or pulses before giving certain medications which would have ordered parameters. Staff U explained he/she assumed that was being done if it was ordered that way. Furthermore, he'she staff was belower medications on the resident's behavior monitoring sheets on the resident's behavior monitoring sheets on the resident's behavior monitoring sheets on the resident's behavior sheets. The facility planmacist failed to identify the irregularity of the facility staff failure to adequately monitor this resident's blood pressure or pulses, and targeted behaviors, while the resident received anti-hypertensive, and targeted polysics, and targeted behaviors, while the resident received anti-hypertensive, and targetes on sources and antianxiety medications, to ensure no adverse consequences with unnecessary medications.

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NOF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	17E534			B. WING			11/25/2015	
ATTICA LONG TERM CARE FACILITY 30			302 N B	OTKIN KS 67009	TE, ZIP CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 428	dementia -(progressic characterized by failing behavioral disturbance physiological condition disorientation and residual disorientation and pain. The Quarterly MDS (7/6/15, revealed the interview for mental serverely impaired conhave delusions, no be rejection of care or woccasionally inconting resident pain assessing pain. The significant changer revealed the resident pain assessment indicated sounds, vocal complain assessment indicated sounds, vocal complain movement or posture possible pain observe back. The CAA (care area at 10/1/15. The cognitive experienced confusion resident had a fall who pelvis. The resident rexpression and though and outbursts of anximal Percocet (narcotic), a solution/ a narcotic) for the control of the contro	we mental disorder and memory, confusion) be, delirium due to know on (sudden severe confusitessness), alzheimers' mental deterioration fusion and memory failuminimum data set), data resident had a BIMS (brotatus) score of 3, indicated the status) score of 3, indicated the status) score of 3, indicated the status of the st	usion, is ure), ed ief ating d id no was The I no the verbal dy or ok ident ed	F 428				

NAME OF PROVIDER OR SUPPLIER ATTICA LONG TERM CARE FACILITY OXA 1D PREFIX PROVIDER SPLAN OF CORRECTION ATTICA, KS 67098		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ATTICA LONG TERM CARE FACILITY CAPITICA LONG TERM CARE FACILITY SUMMARY STATEMENT OF DEFICIENCIES 30.2 N BOTKIN ATTICA, KS 67009 CAPITICA CAPITIC	AND PLAN O	ND PLAN OF CORRECTION IDENTIFICATION NUMB		.rx.	A. Bolebino		OOMI LETEB		
ATTICA LONG TERM CARE FACILITY X0 ID PREPIX CACH DEFICIENCY MUST BE PRECEDED BY FULL RESULTATORY DEFICIENCY MUST BE PRECEDED BY FULL RESULTATORY TAG ORL S.C IDENTIFYING INFORMATION) DEFICIENCY MUST BE PRECEDED BY FULL RESULTATORY DEFICIENCY MUST BE PRECEDED BY FULL RESULTATORY TAG ORL S.C IDENTIFYING INFORMATION) F428 TAG ORL S.C IDENTIFYING INFORMATION PREPIX TAG ORL S.C IDENTIFYING INFORMATION DEFICIENCY ORL S.C IDENTIFYING INFORMATION DEFICIENCY ORL S.C IDENTIFYING INFORMATION ORL S.C IDENTIFYING IN			17E534		B. WING		11/2	5/2015	
CATICA, KS 67009	NAME OF PR	PROVIDER OR SUPPLIER STREET		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
F428 Continued From page 33 722/15 Ativan 1 mg (milligram) every 4 hours po (oral) PRN (as needed) for dementia in other diseases with behavioral disturbance 9/24/15 Morphine solution 20 mg/5 ml (millititer), 0.25 ml - 1 ml every 4 hours as needed for pelvic pain 9/24/15 Percocet 5-325 mg every 4 hours as needed for pelvic pain Standing order for Milk of Magnesia 45 ml orally as needed for constipation. If no bowel movement in 2-3 days, then Dulcolax suppository 1-2 per rectum. Review of the September 2015 MAR (medication administration review) revealed staff administered Ativan 1 mg (milligram) pm 14 times, and lacked effectiveness of the medication 1 time, staff administered Ativan pm 5 times, and lacked effectiveness of the medication 1 time, staff administered Ativan pm 5 times, and lacked effectiveness of the medication 1 time, staff administered the Percocet pm 25 times, and lacked follow-up of the effectiveness of the medication 8 times, and staff administered the Percocet pm 25 times, and lacked fefectiveness of the medication 1 time, staff administered the Percocet pm 35 times, and lacked effectiveness of the medication 8 times, and staff administered the Percocet pm 35 times, and lacked effectiveness of the medication 8 times, and staff administered the Percocet pm 35 times, and staff administered the Percocet pm 35 times, and lacked effectiveness of the medication 8 times, and staff administered the Percocet pm 35 times, and lacked effectiveness of the medication 8 times and lacked effectiveness of the medication 8 times and lacked effectiveness of the medication 8 times and lacked effectiveness of the medication 16 times. Review of the November 2015 MAR, e	ATTICA LONG TERM CARE FACILITY								
7/22/15 Ativan 1 mg (milligram) every 4 hours po (oral) PRN (as needed) for dementia in other diseases with behavioral disturbance 9/24/15 Morphine solution 20 mg/5 ml (millililiter), 0.25 ml - 1 ml every 4 hours as needed for pelvic pain 9/24/15 Percocet 5-325 mg every 4 hours as needed for pain. Standing order for Milk of Magnesia 45 ml orally as needed for constipation. If no bowel movement in 2-3 days, then Dulcolax suppository 1-2 per rectum. Review of the September 2015 MAR (medication administration review) revealed staff administered Ativan 1 mg (milligram) pm 14 times, and lacked effectiveness of the medication 8 times and the staff administered Percocet pm 30 times, and lacked follow-up of the effectiveness of the medication 8 times and lacked effectiveness of the medication 1 time, staff administered Ativan pm 5 times, and lacked effectiveness of the medication 1 time, staff administered the morphine (roxinal) pm 24 times, and lacked effectiveness of the medication 8 times, and staff administered the Percocet pm 35 times, and staff administered the Percocet pm 35 times, and staff administered the Percocet pm 35 times, and lacked follow-up of the effectiveness of the medication 16 times. Review of the November 2015 MAR, evidenced	PRÉFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REC	GULATORY	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF	OULD BE	COMPLETION	
staff administered the prn Percocet and prn Ativan on 11/8/15 and lacked follow-up of the effectiveness of the medication. Furthermore, review of the Bowel movement records from 8/25/15 to 11/23/15, revealed the	F 428	7/22/15 Ativan 1 mg ((oral) PRN (as needed diseases with behavior 9/24/15 Morphine solid 0.25 ml - 1 ml every 4 pain 9/24/15 Percocet 5-32 needed for pain. Standing order for Millias needed for constip movement in 2-3 days 1-2 per rectum. Review of the Septemadministration review Ativan 1 mg (milligrane effectiveness of the mstaff administered Pelacked follow-up of the medication 20 times. Review of the Octobestaff administered Ative effectiveness of the madministered the morand lacked effectiveness in the morand lacked effectiveness and staff administered the Movemstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of the mstaff administered the Ativan on 11/8/15 and effectiveness of t	milligram) every 4 hour d) for dementia in other oral disturbance ution 20 mg/5 ml (millilit hours as needed for plants and plants and plants as needed for plants as needed for plants as needed for plants as needed for plants as needed follow-up of the plants and plants as needed follow-up of the needication.	ter), elvic ally sitory ation stered sked the d d ked mes, m 35 ess	F 428				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
	17E534			B. WING		11/2	5/2015	
NAME OF PF	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•		
ATTICA L	ONG TERM CARE FA	CILITY	302 N B ATTICA,	OTKIN , KS 67009				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 428	resident had a bowel lacked another bowel days). The resident la from 9/25/15 to 10/1/movement from 10/3/lacked bowel moveme (4 days) (had one on movement from 11/4/lacked bowel movement 11/23/15 (9 days). The MAR revealed no November, 2015 On 11/17/2015 at 3:2: stated the resident had administer pain medic the resident had no be then should administer if no results, then state Dulcolax suppository. On 11/18/2015 at 12:: staff G, stated staff staff of stated staff staff ollow-ups for effectiv MAR. Licensed nursin MAR lacked document of the prn medications. On 11/18/2015 at 12:: nursing staff B, verified the prn's on the back documentation expect prn medication given a bowel movement in receive Milk of magne expected to run a rep give the list of those regivered.	movement on 9/9/15, a movement until 9/16/1 acked a bowel movement 15 (6 days), lacked a bot 15 until 10/9/15 (6 days) ent from 10/31/15 to 11 the 4th) and lacked bot 15 to 11/11/15 (9 days) ent from 11/13/15 to 11/11/15 (9 days) ent from 11/13/15 to 11/11/15 (9 days) ent from 11/13/15 to 12 PM, direct care staff I ad pain, and he/she did cation which was effect owel movement in 2 days are the milk of magnesia ff should administer the 123 PM, licensed nursing the 15 pm and 16 pm at 16	5 (6 nt owel s), /4/15 wel , and K, ive. If hys, and g he he ess	F 428				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E534 B. WING 11/25/2015		5/2015			
NAME OF PR	AME OF PROVIDER OR SUPPLIER STREE			RESS, CITY, STA	TE, ZIP CODE	1	
ATTICA LONG TERM CARE FACILITY		302 N B ATTICA	OTKIN , KS 67009				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 428	On 11/23/2015 at 11:3 G, stated if a resident movement for 3 days administer the milk of did not have results, the bowel movement, the for further orders. On 11/23/2015 at 3:13 staff C, verified the boreferred to the standin 11/23/2015 at 10:49 A stated he/she did not had a bowel movement effectiveness of any pursing staff chart the medications. The conhe/she did randomly for effectiveness. 11/23/2015 at 10:49 A stated he/she did randomly for effectiveness. 11/23/2015 at 10:49 A stated he/she did randomly for effectiveness. The facility's policy, dhabits, revealed the life would generate a bow the beginning of the sprotocol as appropria physician for the elde bowel movement in the shifts (3 days). Follow	30 am, licensed nursing a did not have a bowel, then staff should a magnesia. If the reside then on the 4th day of not a physician would be not be physician and the physi	ent to tiffied ursing cy n. ent the ee MAR shift eem at vel y the no r ne	F 428			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C PLAN OF CORRECTION IDENTIFICATION NUMBE					(X3) DATE SURVEY COMPLETED		
	17E534			B. WING	<u>.</u>	11.	11/25/2015	
	ROVIDER OR SUPPLIER			ESS, CITY, STAT	FE, ZIP CODE			
ATTICA L	ATTICA LONG TERM CARE FACILITY			OTKIN KS 67009				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 428	medication monitoring the effects of medication therapy. medication administ to his/her clinical nebe documented on the progress note of the administration. The facility failed confacility monitored the medication for this owith pain and anxiet consultant failed to design the effects of the second the medication for this consultant failed to design the effects of	ations on elders are ations on elders are ations on elders are at the effectiveness of the Each elder's response the effectivened accordeds. All prn medications the MAR and /or nursing efficacy/ outcome of the effectiveness of prn cognitively impaired residence the facility monitors for this cognitively impaired the facility monitors for this cognitively impaired	oo ding will e the dent ity	F 428				